FEDERALLY QUALIFIED HEALTH CENTER OR RURAL HEALTH CLINIC CHANGE IN SCOPE OF SERVICES

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Staff responsible for policy: Finance/Reimbursement

I. Purpose

This policy outlines the procedures necessary for an adjustment to the Medicaid Prospective Payment System (PPS) rate for any increases or decreases in the scope of services furnished by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) that subcontract (either directly or indirectly) to provide covered services to Medicaid enrollees with a Managed Care Entity (MCE).

Under the Benefits Improvement and Protection Act of 2000 (BIPA), AHCCCSA is required to adjust the FQHCs' or RHCs' initial base rate per visit under the PPS to take into account increases or decreases in the scope of services furnished by the FQHC or RHC.

The methodology for establishing the initial PPS rate is described in the State Plan Amendment (SPA) 4 19-B and approved by the Department of Health and Human Services Centers for Medicare and Medicaid Services.

Background

The federal requirement that established the PPS for FQHCs and RHCs specified the calculation of a minimum rate (BIPA Rate) per visit for each FQHC/RHC for services provided to Medicaid enrollees. The baseline BIPA rate is a unique payment rate established for each FQHC/RHC based on the average of each FQHC's/RHC's fiscal years 1999 and 2000 reasonable cost per visit. AHCCCSA determined the baseline reasonable cost rate using the FQHC's/RHC's Medicare cost report and adjusting the costs to include services not covered under Medicare but covered under Medicaid, such as laboratory and radiology and excluded costs covered under Medicare but not included under Medicaid such as provisions for bad debt expenses. For FY 2002 and subsequent years, the rate per visit equals the previous year's per visit rate adjusted by the Medicare Economic Index (MEI) and any change in the FQHC's/RHC's scope of services. There is no provision for rebasing of the rates under the BIPA methodology.

States may select an Alternative Payment Methodology (APM) as long as that methodology (1) reimburses FQHCs/RHCs at least what they would receive under the PPS, (2) is agreed to by the FQHC/RHC, and (3) the methodology must be described in the approved SPA. Through a series of discussions with the Arizona Association of Community Health Centers (AACHC), AHCCCSA developed an alternative payment methodology that used the

physician services component (PSI) of the CPI as an index to inflate the payment rate and allows for rebasing of the rates every third year.

By rebasing the rates every third year, using the same methodology as described above for determining the baseline PPS rate, AHCCCSA eliminates adjustments due to changes for scope of services as the rebasing would account for all changes (decreases as well as increases) in scope of services.

If an FQHC/RHC submits a request for a rate adjustment due to changes in scope of services and the change in scope of services meets a minimum threshold (e.g. +/- 5%) on the per visit rate, the per visit rate for the FQHC/RHC is no longer computed using the alternative payment methodology rather the rate is computed based upon the BIPA PPS rate methodology. By doing so, AHCCCSA complies with the federal mandate that the APM result in a payment to the FQHC/RHC that is at least equal to the amount to which it is entitled under the BIPA PPS rate methodology. The annual PPS rate is computed using the BIPA methodology until such time as the rate computed using the APM equals or exceeds the PPS rate using the BIPA methodology.

II. Definitions

Federally Qualified Health Care Centers (FQHCs) – FQHCs are facilities or programs more commonly known as Community Health Centers, Migrant Health Centers and Health Care for the Homeless Programs. An entity may qualify as an FQHC if it: (i) receives a grant and funding pursuant to Section 330 of the Public Health Service Act; (ii) is receiving funding from such a grant under a contract with the recipient of a grant and meets the requirements to receive a grant pursuant to Section 330 of the Public Health Service Act; (iii) is determined by the Secretary of DHHS to meet the requirements for receiving such a grant (look-alike) based on the recommendation of HRSA within PHS; or, (iv) was treated by the Secretary of the DHHS as a Federally Funded Health Center (FFHC) for purposes of Part B Medicare as of January 1, 1990. An FQHC includes an outpatient program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (PL 93-638) or an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1, 1991.

Rural Health Clinics (RHCs) – RHCs are clinics located in areas designated by the Bureau of Census as rural and by the Secretary of DHHS as medically underserved or having an insufficient number of physicians and meets the requirements under 42 CFR 491. An entity may qualify if it is (a) Designated by the Secretary as an area with shortage of personal health services under section 330(b)(3) of the Public Health Service Act; (b) Designated by the Secretary as a health professional shortage area under section 332(a)(1)(A) of the public Health Service Act because of its shortage of primary medical care professionals; (c) Determined by the Secretary to contain a population group that has a health professional shortage under section 332(a)(1)(B) of that Act; or (d) Designated by the chief executive

officer of the State and certified by the Secretary as an area with a shortage of personal health services.

Current Period – The time period for which the FQHC/RHC is claiming a significant change (increase or decrease) in scope of services occurred. A change will not be considered significant, unless it impacts the base rate by 5% or more.

Prior Period – The FQHC's/RHC's fiscal year preceding the fiscal year in which there was a change (increase or decrease) in the scope of services. **FQHCs/RHCs must have incurred at least six months of actual expenses before submitting a request for a rate adjustment based on a change in scope of services.**

Scope of Service Change – Change in the type, intensity, duration and/or amount of covered Medicaid services (covered under the Medicaid State Plan and approved by the Secretary of the Department of Health and Human Services) that meet the definition of FQHC/RHC services as defined in section 1905 (a) (2) (B) and (C) of the Social Security Act. A change in the cost of a service is not considered in and of itself a change in the scope of services.

Scope of service changes must meet the following criteria: a) an addition or deletion of an FQHC/RHC covered service must be AHCCCS covered services; b) a change in the magnitude, intensity or character of currently offered covered services (demonstrated by an increase or decrease in the Relative Value Units (RVUs) associated with covered services and/or changes in the mix of providers delivering the services) that may reasonably be expected to span at least one year; c) changes due to opening a new site, (including mobile units) or closing an existing clinic site; d) a building expansion of an existing site; and d) a change in applicable medical technologies and medical practices. In order to qualify for a PPS rate change, the **incremental cost** associated with the scope of services changes must be equal to at least a cumulative 5% total difference in the allowable cost per visit and be supported by six months of actual cost data. The request and all required supporting documentation for the adjustment based on a change in scope of services must be submitted within one year of the commencement of the qualifying change in scope of services.

Title XIX Member - Member eligible for Federally funded Medicaid programs under Title XIX of the Social Security Act including those eligible under 1931 provisions of the Social Security Act (previously AFDC), Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI), SSI-related groups, Title XIX Waiver Groups, Medicare Cost Sharing Groups, Breast and Cervical Cancer Treatment Program and Freedom to Work Program.

Visit – Visit - A face to face encounter between a patient and a health professional -

- a physician,

- a dentist or oral surgeon,
- a dental hygienist (when services are billed under the dentist's license number),
- a physician assistant,
- a nurse practitioner,
- a nurse midwife,
- a home health and visiting nurse, (to the homebound in an area where the Centers for Medicare & Medicaid Services (CMS) has certified that there exists a shortage of home health agencies),
- a registered dietician (pursuant to a referral by a physician and as defined in section 1861 subsection (r)(1) of the Social Security Act),
- a clinical psychologist, or
- a clinical social worker,

during which an AHCCCS covered service (as specified in Title 9, Chapter 22, Article 2 and Title 9, Chapter 28, Article 2 of the Arizona Administrative Code is rendered. . Visits with more than one health professional within the same discipline (e.g. medical, dental and behavioral health for a maximum of three visits) and multiple visits with the same health professional which take place on the same day and at a single location, constitute a single visit, except for cases in which the patient, subsequent to the first visit, suffers an illness or injury requiring additional diagnosis or treatment. For purposes of the annual reconciliation, only those visits associated with Title XIX eligible members should be counted. Title XXI, Federal Emergency Services, Social Security Disability Insurance-Temporary Medical Coverage, Healthcare Group members and any State only populations are excluded from the annual reconciliation.

Incremental Cost – Increases or decreases in costs resulting directly from a change in scope of services provided by the FQHC/RHC. **FQHCs/RHCs must have incurred at least six months of actual expenses before submitting a request for a rate adjustment based on a change in scope of services.**

III. Policy

A. Request for PPS Rate Adjustment Based on Change in Scope of Services

1. All requests should be submitted in writing to the Division of Health Care Management (DHCM) by the Director/Administrator of the FQHC/RHC and should include: a) a detailed explanation of **each** change in scope of services provided by the FQHC/RHC delineating how services were provided both before and after the change; b) the effective date of each change in scope of services; c) the Medicaid visits and total visits associated with each change in scope of services; d) the total number of visits for all sites for the same time period that the FQHC/RHC submits the incremental costs; e) a trial balance (based on the FQHCs'/RHCs' fiscal year) for

both the prior period and the current period; f) the incremental increase or decrease in costs by expense category, as described in this policy, for each change in scope of services; and g) the cumulative per visit dollar amount of the PPS rate adjustment requested.

2. All requests should include, at a minimum, a detailed worksheet that delineates the total **incremental** difference in costs for each of the categories and subcategories of expenses associated with the change in scope of services **in the format outlined in Attachment A**.

3. The FQHC/RHC shall submit supporting documentation for each amount included in the categories of expenses specified in paragraph two of this policy for both the prior period and the period where there is a change in the scope of services including, but not limited to, **the documentation as described in Attachment A.**

4. The FQHC/RHC shall compute the increase/decrease in the PPS Rate for a change in scope of services **using the format and methodology as provided in Attachment B.**

B. AHCCCS Review and Approval of Request for PPS Rate Adjustment

1. AHCCCS will review the documentation submitted and will notify the FQHC/RHC within sixty (60) days as to whether a PPS rate adjustment will be approved. The detailed supporting documents submitted with the request for the rate adjustment may not provide the level of detail to make a determination within the sixty day timeframe. AHCCCS will communicate that additional information is necessary to make the determination and request additional supporting documentation. If approved, the PPS rate change will reflect the per visit incremental cost difference of the scope of service change and will be reflected in the PPS rate for services provided in the federal fiscal year in which the change in scope of service took place. The revised PPS rate adjusted for changes in scope of services may not exceed the cost per visit calculated from the most recent audited cost report. AHCCCS may prorate the adjusted rate per visit, depending on the dates of service of visits associated with the changes in scope of services. If AHCCCS determines that a PPS rate change is not appropriate, AHCCCS will provide a written explanation of its decision within sixty (60) days. The FQHC/RHC has the right to appeal the decision through the AHCCCS grievance process.

2. In order to verify the data submitted by the FQHC/RHC, an analytical review will be performed to test cost allocations and/or the reasonableness of costs submitted as incremental increases/decreases in costs. Based on the outcome of the review, additional supporting documents may be requested from the FQHC/RHC to

determine if the information submitted represents annual cost increases and/or decreases. If further detail is needed, a request for the additional information will be communicated or a field review may be conducted of a limited scope.

3. Payments and or recoupments resulting from an approved rate adjustment related to a change in scope of services will be paid with the next regularly scheduled quarterly supplemental payment.

4. Payments resulting from PPS rate adjustments and corresponding adjustments to prior year annual reconciliations are subject to the two year limitation as stated in 45 CFR Subtitle A § 95.7 therefore, requests for rate adjustments due to changes in scope of services must be submitted within one year of the change in scope of services.

IV. Timeliness, Accuracy and Completeness

The submission of late, inaccurate, or otherwise incomplete requests shall not be considered. Standards applied for determining adequacy of required data are as follows:

A. Timeliness: Requests for rate adjustments due to a change in the scope of services provided by the FQHC/RHC will be submitted in writing, within one year of the date of change in scope of services. Requests will be submitted to AHCCCS' Division of Health Care Management to the attention of the Finance and Reinsurance Manager.
B. Accuracy: Schedules and supporting documents or other required data will be prepared in strict conformity with appropriate authoritative sources and/or AHCCCS defined standards.
C. Completeness: All schedules and supporting documents and other required data should be fully disclosed in a manner that supports the rate adjustment requested with no material omissions.

V. References

- State Plan Amendment *(SPA)* 03-007
- Benefits Improvement and Protection Act of 2000 *(BIPA)*
- Section 1902 of the Social Security Act *(42U.S.C. 1396aa)*
- Section 1905 (a)(2)(B) and (C) of the Social Security Act (*42 U.S.C. 1396d)*